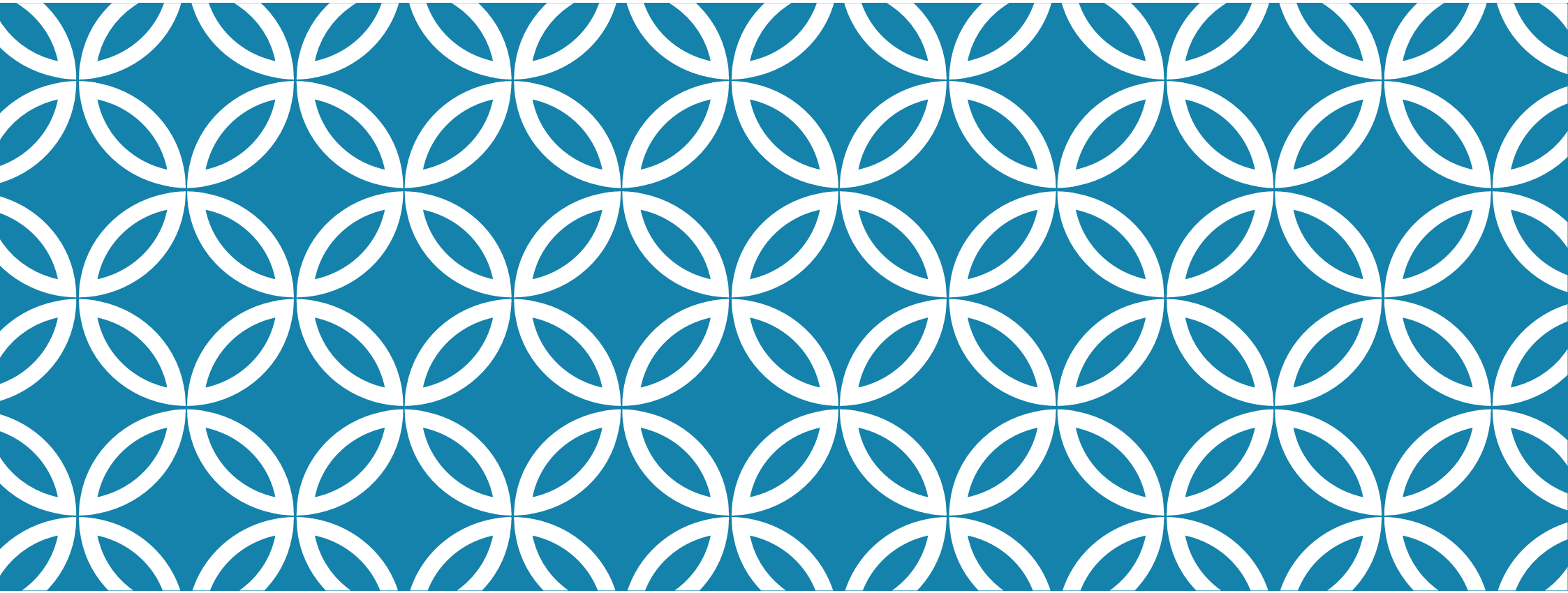

THE PREVENTION OF OFFENDING BEHAVIOUR BY PEOPLE WITH INTELLECTUAL DISABILITIES: A CASE FOR SPECIALIST CHILDHOOD AND ADOLESCENT EARLY INTERVENTION

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INTRODUCTION - CHILDREN AND ADOLESCENTS WITH ID

- Children and adolescents with ID are especially vulnerable to mental health issues and challenging behaviour. This is due to a combination of factors:
  - psychosocial disadvantage (Emerson and Hatton, 2007)
  - stigma (Ali et al., 2015)
  - bullying (Hatton et al., 2018)
  - poor communication skills
  - sensory disabilities
  - genetic syndromes and behavioural phenotypes (Powis and Oliver, 2014).
  - epilepsy
  - physical illness
  - effects of medications
  - abusive experiences
  - the experience of failure, especially in educational settings, in comparison to siblings and similar age peers (Zigler et al., 1999, 2002).
  - Navigating the same challenges and tasks experienced by all young people, without having equal degrees of intellectual ability and social capacity (O'Brien and Bell, 2004) and a more limited range of coping strategies (Allington-Smith, 2006).

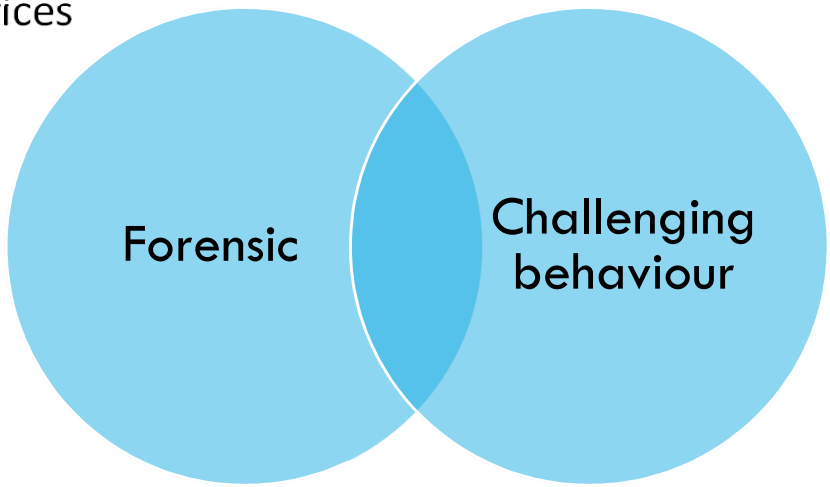
CHALLENGING VS OFFENDING BEHAVIOUR

Challenging behaviour

- what would be classified as a crime and conviction for someone without intellectual disability may often be labelled as “challenging behaviour” in someone with intellectual disability (Emerson & Einfield, 2011),
- behaviour may not be reported by family/paid carers
- insufficient evidence to gain a conviction (communication issues of victim etc.)
- offences may also be reported to authorities, but not pursued/processed

Forensic

- More likely to get caught
- Less able to conceal actions
- More likely to confess
- More closely supervised
- Lack of services



INTRODUCTION – YOUNG OFFENDERS WITH ID

- ID over represented in populations of adolescent offenders (Gralton, 2013).
- Approximately 20% (Chitsabesan et al., 2007; Shelton, 2006).
- Despite significant under recognition of this group within custodial settings (Ford et al., 2008).
- Shelton (2006): high use of incarceration as a method of control for children with behavioural problems ***"dumping of…youth with troubled and troublesome behaviours into the juvenile justice system"*** (p. 42).

INTRODUCTION

One study examined age-related variables of patients admitted to four secure services in the UK:

- age at first conviction
- age at admission to secure services.

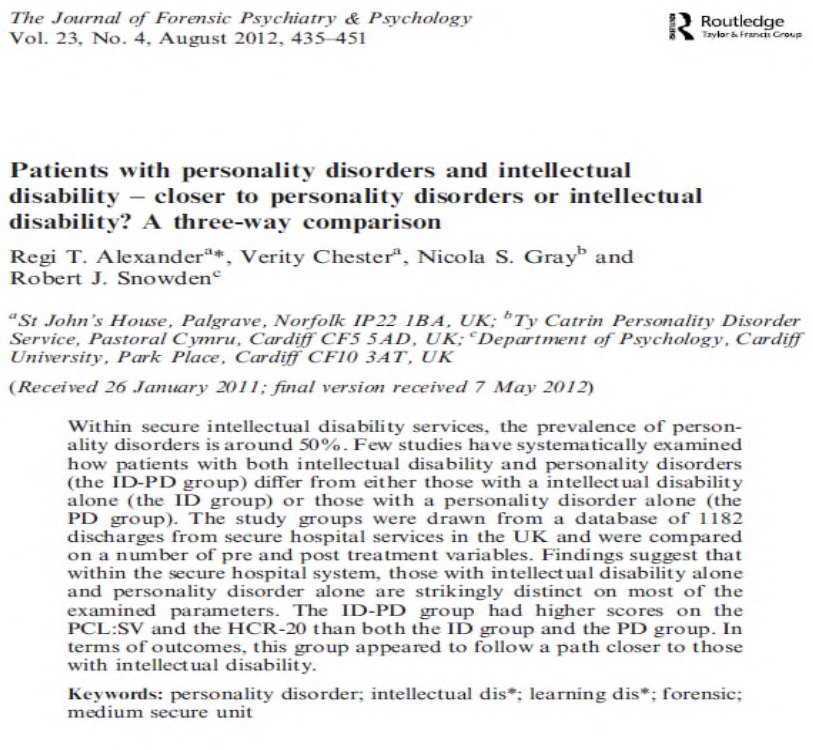
The study compared these variables between:

- patients with ID alone
- personality disorder (PD) alone
- those with comorbid ID and PD.

Patients with PD alone were significantly younger at first conviction (aged 16) than those with ID alone, or ID and PD (aged 19).

No significant differences on the age at admission to forensic services, which was 25-30 years of age.

While these findings provide an indicator of the onset of forensic issues, it is likely that patients' needs will have been evident much earlier.



The Journal of Forensic Psychiatry & Psychology
Vol. 23, No. 4, August 2012, 435–451

Routledge
Taylor & Francis Group

Patients with personality disorders and intellectual disability – closer to personality disorders or intellectual disability? A three-way comparison

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(*Received 26 January 2011; final version received 7 May 2012*)

Within secure intellectual disability services, the prevalence of personality disorders is around 50%. Few studies have systematically examined how patients with both intellectual disability and personality disorders (the ID-PD group) differ from either those with a intellectual disability alone (the ID group) or those with a personality disorder alone (the PD group). The study groups were drawn from a database of 1182 discharges from secure hospital services in the UK and were compared on a number of pre and post treatment variables. Findings suggest that within the secure hospital system, those with intellectual disability alone and personality disorder alone are strikingly distinct on most of the examined parameters. The ID-PD group had higher scores on the PCL:SV and the HCR-20 than both the ID group and the PD group. In terms of outcomes, this group appeared to follow a path closer to those with intellectual disability.

Keywords: personality disorder; intellectual dis*; learning dis*; forensic; medium secure unit

INTRODUCTION - PREVENTION BETTER THAN CURE?

- Elucidating when behavioural issues arise in children and adolescents with ID could support future service development, in order to ensure that the right services are offered at the right time in the life course, i.e. prior to such behaviour reaching a forensic threshold.

- Recent policy initiatives in the UK are emphasising the importance of early intervention for those with ID and/or challenging behaviour, mental disorders, or forensic issues, in order to reduce the need for inpatient admissions (NHS England, 2015).

AIMS

- This study therefore aims to identify the age at which antisocial and violent behaviour was first observed among a cohort of inpatients within a forensic ID service.

METHOD

Setting

- The study took place in a 95-bed inpatient ID forensic service, with medium secure, low secure, and rehabilitation wards.

Participants

- Eighty-four patients were included in the study.
- 50 men, 33 women, and one patient who identified as transgender.
- The mean age of the patients was 34 (range 18-60).

METHOD

Measure

- The Historical Clinical Risk Management-20, Version 3 (HCR-20V3, Douglas, K. S., Hart, Webster, & Belfrage, 2013).
- The HCR-20V3 is a structured clinical judgment tool which systemically guides the clinician through a series of risk factors that they must decide which are present or absent for any patient being assessed.
  - historical factors
  - current clinical presentation
  - future risk factors
- This measure includes age data and qualitative evidence for two items;
  - **H1 History of Problems with Violence** - any actual, attempted of threatened harm of another person, incorporating arson and sexual offences.
  - **H2 History of Problems with Other Antisocial Behaviour** - any actual, attempted or planned violation of the rights, safety, or well-being of others that violate social norms.
  - The clinician is asked to score the presence or absence of the behaviour at different time points;
  - as a Child (12 and under)
  - as an Adolescent (13 – 17)
  - as an Adult (18 and over)

METHOD

Procedure and Analysis

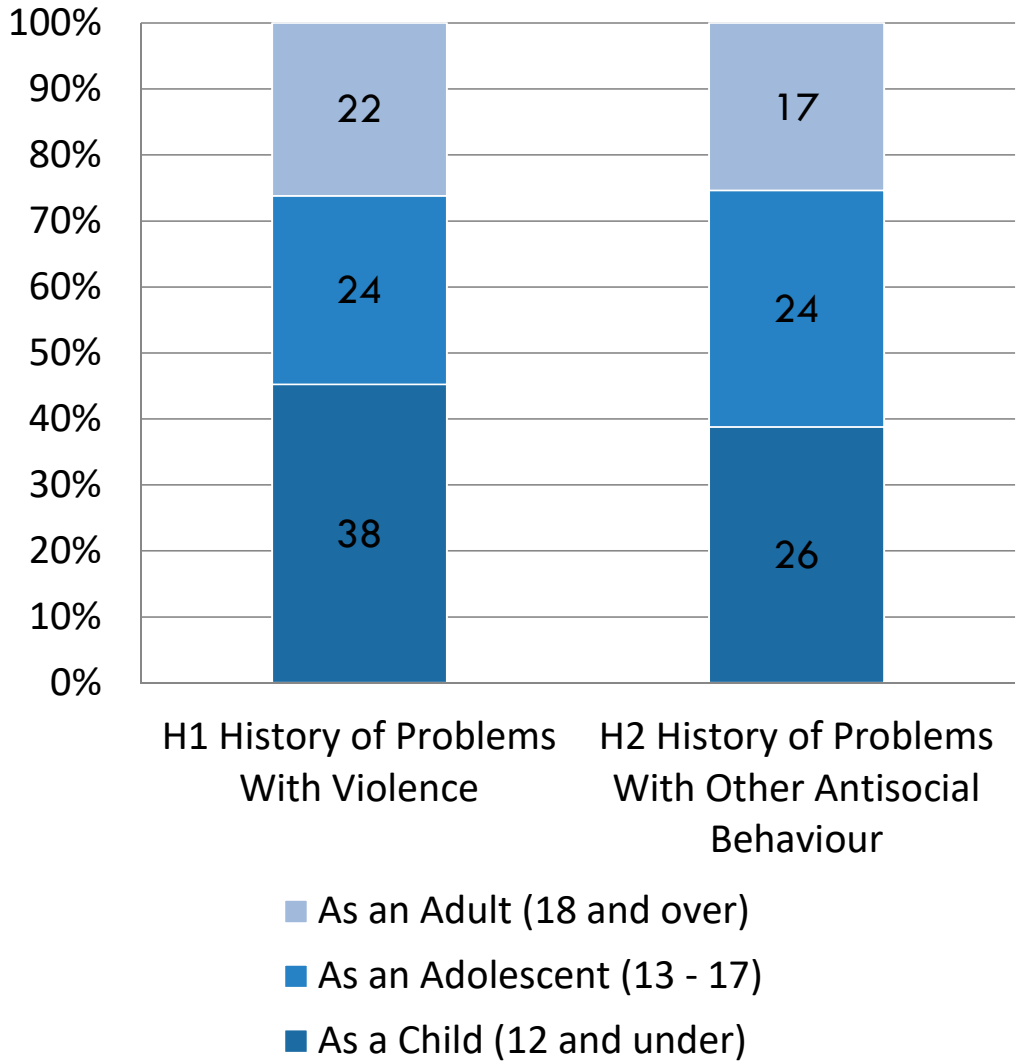
- HCR-20^{V3} data for each patient aggregated, then anonymised, in accordance with the DPA and the GDPR.
- Descriptive statistics are provided.

Ethical Considerations

- The study utilised data from assessments that are routinely competed with the service.
- Informed consent is gained from patients prior to assessments completion.
- The project fulfilled criteria for service evaluation and did not require approval from a NHS Research Ethics Committee guidance (Health Research Authority, 2017),

RESULTS

- H1: 38 (45%) first had problems documented as a child, 24 (29%) as an adolescent.
- H2: 26 patients (39%) problems were first documented when the patient was a child, 24 (36%) as an adolescent.



RESULTS

Item		n	%	Exact age	
				Mean	Range
H1†	As a child (12 and under)	38	45	8	2 - 12
	As an Adolescent (13 - 17)	24	29	15	13 - 17
	As an Adult (18 and over)	22	26	25	18 - 32
H2*	As a child (12 and under)	26	39	9	4 - 12
	As an Adolescent (13 - 17)	24	36	15	13 - 17
	As an Adult (18 and over)	17	25	20	18 - 27

DISCUSSION – OPPORTUNITIES FOR INTERVENTION

- Findings suggests that early intervention services could have a role in targeting factors which could reduce future offending, and improve outcomes in this population (Newman et al., 2013).
- Until 30 years ago, a major component of lifespan ID services was a mental health service for young people; however, this assistance is now considerably reduced (The Royal College of Psychiatrists, 2016).
- Two models of mental health service delivery are available for children and adolescents with ID;
  - the Child and Adolescent Mental Health Service (CAMHS)
  - the community ID team (Gangadharan et al., 2001).
- However, this means that this group can fall between the gaps of these two services (Gangadharan et al., 2001).
- A third option is a dedicated ID service, with trained staff and clinicians, integrated into the Child and Adolescent Mental Health Service (CAMHS-ID) (Gangadharan et al., 2001).

- While early intervention is advocated, caution that this group should not face a lifelong future in institutional care (Lenehan, 2017).
- Prolonged inpatient stays are most likely in areas without fully developed care pathways. Unfortunately, community CAMHS-ID are not well developed in many areas of the country (NHS England, 2014).
- Care inappropriately shifted to secure social and residential schools, which are often a long geographical distance from the family home (Gralton, 2013).
- There is a negative impact on family life, with an increased likelihood of sibling and parental emotional distress, and family breakdown (Bernard and Turk, 2009).
- Placements are high cost, with rates cited as ranging from ranging from £130,291 to £266,968 per year in 2012 (Sholl et al., 2014).
- In practice, many young people remain in out of area residential placements as adults (Department of Health, 2007).

DISCUSSION - SERVICE AVAILABILITY

Generic or specialist?

- When accessing generic CAMHS, those with ID are less likely to have their psychiatric and developmental needs recognised, understood and addressed in an evidence-based and optimally therapeutic fashion, largely due to a lack of specialised expertise and resources required to provide comprehensive assessments and ongoing management (Bernard and Turk, 2009; Gralton, 2013).

AVAILABILITY VS. EFFICACY - KEIRAN*

- Problematic behaviour particularly within school.
- Known to mainstream CAMHS since early childhood
- No diagnosis established
  - Autistic traits reported continually through notes
  - Psychotic symptoms present through case history – reported "sceptically"
  - Attachment/trauma
- Negative attitudes from professionals evident in case-notes
- No interventions offered
- Lived at home with dad, with some informal restrictions of liberty
- Admitted to an inpatient secure/forensic intellectual disability service aged 18 following an offence of arson.
- Offence appeared directly linked to his psychotic hallucinations.
- High profile public "wanted person" campaign regarding the offence, considerable ill feeling in the local community.
- **Progress:**
  - Autism diagnosis made following assessment
  - Antipsychotic medication commenced – reduction in auditory phenomena
  - High level of engagement with different therapies offered within the service.

POLICY VS PRACTICE

- Failure to reduce hospital placements within the forensic cohort:
  - ongoing needs relating to forensic risk
  - a lack of specialised community service provision
  - mental ill health
  - **Minimal focus given to children/adolescents?**

Local Government Association | Directors of adass adult social services | NHS England

Building the right support

A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition

October 2015

3.7 In the main, however, the challenge facing commissioners is as much about preventing new admissions and reducing the time people spend in inpatient care by providing alternative care and support, as it is about discharging those individuals currently in hospital. The task requires: advocacy, early intervention, prevention, ensuring the right set of services are available in the community.

RECOMMENDATIONS

- Those with ID presenting in childhood and adolescence with antisocial and/or violent behaviour need to be prioritised for access to services.
- There are several promising care models for those exhibiting such issues in childhood and adolescence:
  - parenting programmes
  - training and support for families
  - positive behavioural support (PBS) (Cooper et al., 2014)
  - respite and therapeutic interventions (Reid et al., 2013; Sholl et al., 2014)

THANK YOU FOR LISTENING

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The prevention of offending behaviour by people with intellectual disabilities: a case for specialist childhood and adolescent early intervention

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Abstract

Purpose – *Elucidating where antisocial or violent behaviour arises within the life course of individuals with intellectual disability (ID) could improve outcomes within this population, through informing services and interventions which prevent behaviours reaching a forensic threshold. The paper aims to discuss this issue.*

Design/methodology/approach – *The Historical Clinical Risk Management-20, Version 3 assessments of a cohort of 84 inpatients within a forensic ID service were analysed for this study, with a particular emphasis on items concerned with the age at which antisocial or violence first emerged.*

Findings – *For most participants, violent or antisocial behaviour was first observed in childhood or adolescence. The study also highlighted a smaller subgroup, whose problems with violence or antisocial behaviour were first observed in adulthood.*

Originality/value – *The study findings suggest that targeted services in childhood and adolescence may have a role in reducing the offending behaviour and forensic involvement of people with ID. This has implications for the service models provided for children and adolescents with ID with challenging or offending behaviour.*

Keywords *Learning disability, Youth, Forensic, Secure, HCR-20, Developmental disability*

Paper type *Research paper*